STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING _____ B. WING _____	C 01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	**5700 WILKIE DR FORT WAYNE, IN 46804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00142592.

Complaint IN00142592 substantiated. No deficiencies related to the allegations are cited.

This visit was in conjunction with the Recertification and State Licensure Survey.

Survey dates: January 22, 23, 24, 27, 28, 29, & 30, 2014

Facility number: 000476
Provider number: 155446
AIM number: 100290870

Survey team:
Sue Brooker RD TC
Martha Saull RN
Julie Call RN
(January 22, 23, & 24, 2014)

Census bed type:
SNF/NF: 113
Total: 113

Census payor type:
Medicare: 12
Medicaid: 73
Other: 28
Total: 113

Sample: 3

Covington Manor Health and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 regard to the Investigation of Complaint IN00142592. Quality review completed on February 3, 2014 by Randy Fry RN.	F 000		